Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 01 - MAIN BUILDING 01 B. WING TN1803 08/01/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 456 WAYNE AVENUE WYNDRIDGE HEALTH AND REHAB CTR CROSSVILLE, TN 38555 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 831 1200-8-6-.08 (1) Building Standards N 831 What corrective action(s) will be A nursing home shall construct, arrange, and accomplished for those residents found maintain the condition of the physical plant and to have been affected: the overall nursing home environment in such a manner that the safety and well-being of the It was determined that no residents were residents are assured. Adversely affected by this deficiency 2. How you will identify other residents having the Potential to be affected This Rule is not met as evidenced by: by the same deficient Practice and what corrective action will be taken Based on observations, the facility failed to maintain the overall physical enviornment for the safety of the patients. All residents of the facility have the potential to be affected. The findings included: What measures will be put into place 1. Observation on 8/1/16 at 9:56 AM, revealed or what Systematic changes you will sagging and busted ceiling tiles above the toilet in make to ensure that the Deficient the bathroom of patient room 107. practice does not occur: 2. Observation on 8/1/16 at 10:01 AM, revealed night lights not working in the patient rooms of 1) Maintenance Department replaced 120 and 213. damaged Ceiling tile in room 107 8/5/16 These findings were verified by the maintenance 2) Maintenance Department replace director and acknowledged by the administrator light bulbs In night light in rooms during the exit conference on 8/1/16, 120 and 213 8/5/16 4 How the corrective action(s) will be N 848 1200-8-6-.08 (18) Building Standards N 848 monitored to Ensure the deficient practice will not recur, i.e., what quality assurance (18) It shall be demonstrated through the program will be put into place submission of plans and specifications that in each nursing home a negative air pressure shall be maintained in the soiled utility area, toilet room, janitor 's closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including. but not limited to, clean linen rooms and clean

Division of Health Care Facilities

utility rooms.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Adnistair

(X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICENTERS FOR MEDICARE & MEDICAID SERV			FORM APPROVED MB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE AND PLAN OF CORRECTION IDENTIFICATION NU	IMPED	TIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
445304	8 WING	<u> </u>	08/01/2016
NAME OF PROVIDER OR SUPPLIER WYNDRIDGE HEALTH AND REHAB CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 456 WAYNE AVENUE CROSSVILLE, TN 38555	1 000112016
(X4) ID SUMMARY STATEMENT OF DEFICIENCE PREFIX (EACH DEFICIENCY MUST BE PRECEDED B TAG REGULATORY OR LSC IDENTIFYING INFORM	YFULL PREF	IX (EACH CORRECTIVE ACTION SHOULD	BE COMPLETION
	N8	Maintenance Director and Assistant Maintenance Director will monitor ceili tiles on monthly Check list. Maintenance Director and Assistant Maintenance Will monitor all night lights on monthly check List. Directors will present monthly check List to QAPI committee	ng
			: : : :

PRINTED: 08/04/2016 FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 01 - MAIN BUILDING 01 B. WING_ TN1803 08/01/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **456 WAYNE AVENUE** WYNDRIDGE HEALTH AND REHAB CTR CROSSVILLE, TN 38555 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N 848 Continued From page 1 N 848 N848 1. What corrective action(s) will be accomplished for those residents found This Rule is not met as evidenced by: to have been affected: Based on observations, the facility failed to maintain the correct negative air pressure where It was determined that no residents were required. Adversely affected by this deficiency The findings included: 2. How you will identify other residents having the Potential to be affected 1. Observation on 8/1/16 at 9:27 AM, revealed the by the same deficient Practice and clean side (dryer) room had negative air pressure what corrective action will be taken flowing from the dirty side (washers) room. All residents of the facility have the 2. Observation on 8/1/16 at 9:46 AM, revealed the potential to be affected. 100 hall storage (janitor's closet) negative exhaust fan not operating. What measures will be put into place These findings were verified by the maintenance director and acknowledged by the administrator or what Systematic changes you will make to ensure that the Deficient during the exit conference on 8/1/16. practice does not occur: N1410 1200-8-6-.14(2)(a)5 (ii) Disaster Preparedness N1410 1) Maintenance department will remove fan In washer room (2) Physical Facility and Community Emergency to maintain correct flow. 8/5/16 Plans. 2) Maintenance department installed (a) Physical Facility (Internal Situations). new Exhaust fan in 100 hall storage janitors closet. 8/19/16 Each of the following disaster preparedness plans shall be conducted annually prior to the

at least three (3) years.

month listed in the plan. Drills are for the purpose of educating staff, resource

determination, testing personnel safety provisions and communications with other facilities and community agencies. Records which document and evaluate these drills must be maintained for

CENTER	S FOR MEDICARE	E & MEDICAID SERVICES			C)MB N	0. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		445304	8 WING	·			8/01/2016
	ROVIDER OR SUPPLIER			456	EET ADDRESS, CITY, STATE, ZIP CODE WAYNE AVENUE OSSVILLE, TN 38555	_10	8/01/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
-			N8	n pi qı	Int Jow the corrective action(s) will be attorished to Ensure the deficient ractice will not recur, i.e., what wallty assurance program will be put into place.		
				M ne Çi h	faintenance Director and Assistant faintenance Director will monitor egative exhaust Fans on monthly heck list. Directors will present nonthly check List to QAPI emmittee.		· •
				1			
				•			
			; ;				:
							!
				!			:
			• 1	1			! !
	!			:			!

PRINTED: 08/04/2016

FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` .	E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED				
		l Dolebino.	OT - INAIN BUILDING OF					
	TN1803	B. WING		08/01/2016				
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE					
WYNDRIDGE HEALTH AND REHAB CTR 456 WAYNE AVENUE CROSSVILLE, TN 38555								
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IÐ PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED (CROSS-REFERENCED TO THE APPROPRIED (CROSS-REFERENCE)	D BE COMPLETE				
N1410 Continued From pa	ge 2	N1410						
(ii) External disaste	er procedures plan (for hquake), to be exercised prior							
 (I) Staff duties by department and job assignment; and, (II) Evacuation procedures. This Rule is not met as evidenced by: Based on document review, the facility failed to 			What corrective action(s) will be accomplished for those residents found to have been affected:	i				
			It was determined that no residents w Adversely affected by this deficiency	,				
conduct the required earthquake disaster preparedness drill.			 How you will identify other residenthaving the Potential to be affected by the same deficient Practice and what corrective action will be taken 	ts ·				
The findings included: Document review on 8/1/16 at 10:01 AM, revealed the facility failed to conduct an earthquake preparedness drill during 2015. This finding was verified by maintenance and acknowledged by the administrator during the exit conference on 8/1/16.			All residents of the facility have the potential to be affected					
			3. What measures will be put into place or what Systematic changes you will make to ensure that the Deficient practice does not occur: 3. What measures will be put into place. 4. The proof of the put into place in the proof of the practice does not occur: 4. The proof of the put into place in the place of the proof of the put into place. 5. The put into place or what such a put into place					
			Maintenance director will conduct annual Earthquack drill.	8/24/16				
		4.	How the corrective action(s) will be monitored to Ensure the deficient prac will not recur, i.e., what quality assurar program will be put into place					
			Maintenance Director and Assistant Maintenance Director will monitor and conduct external disaster Procedur for tornado, flood, earthquake. Will be exercised prior to March. Disaster procedures will be presented to QAPI committee	es				